STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445162	A. BUILDING _____ B. WING _____	R 08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PLACE AT JOHNSON CITY	105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604

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F 000	INITIAL COMMENTS On August 21-22, 2012 a first follow-up survey was completed for the annual recertification survey conducted on June 16, 2012. During the first follow-up visit tag F-323 was found not in substantial compliance as stated on the facility's plan of correction alleging a compliance date of August 10, 2012. F-323 was recited and a new tag, F-280, not previously cited on the annual survey, was cited.	F 000	**The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.**	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	**F280 Right to participate planning care-revise CP** 1. On 8/22/12, foley catheter care was updated on the Care Plan for Resident # 2, #14, & #9 by the D.O.N. and/or A.D.O.N. 2. The DON or one of the following: ADON, RN Supervisor, Wound Care Nurse, LPN Supervisor, or the Charge Nurse will audit all Resident's Care Plans to ensure they include correct foley catheter care information. To be completed by 8/23/12. 3. By 8/24/12, the DON and/or ADON will re-educate licensed	8/23/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark de Hunter	Administrator	9/7/12

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F 280	Continued From page 1 Based on medical record review and interview, the facility failed to revise the care plan for three residents (#2, #9, and #14) of eighteen residents reviewed. The findings included: Resident #2 was admitted to the facility on February 22, 2012, with diagnoses including Paranoid Schizophrenia, Venous Stasis Ulcers, and Hypertension. Medical record review of a physician's order dated July 17, 2012, revealed "...may replace foley catheter if does not void before 7pm tonight..." Medical record review of the current Interdisciplinary Care Plan last reviewed August 10, 2012, revealed no updates to reflect the indwelling catheter was discontinued on July 17, 2012. Interview with the Assistant Director of Nursing (ADON) on August 22, 2012, at 11:40 a.m., confirmed the Care Plan had not been revised to reflect the resident no longer had an indwelling uninary catheter. Resident #9 was admitted to the facility on July 9, 2010, with diagnoses including Muscle Weakness, Senile Dementia, and Incontinence. Medical record review of the physician's recapitulation orders dated August 2012, revealed "...change 20 Fr (French) Foley cath (catheter) prn (as needed)..."	F 280	nursing staff on updating the care plan with foley catheter information. The DON or one of the following: ADON, RN Supervisor, Wound Care Nurse, LPN Supervisor, or the Charge Nurse will conduct random audits of resident care plans with indwelling foley catheters to ensure correct foley catheter information is on the care plan. Audits will be completed on 5 residents per week for 4 weeks, then 10 residents per month for 3 months. To begin 8/29/12. 4. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate. To begin with August data at the September Q.A. meeting.	

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F 280	Continued From page 2 Medical record review of the current Interdisciplinary Care Plan last reviewed August 14, 2012, revealed "...foley cath change Q (every) month and PRN..." Interview with the Assistant Director of Nursing (ADON) on August 22, 2012, at 11:40 a.m., confirmed the Care Plan had not been updated to reflect the resident's indwelling urinary catheter was to be changed as needed not every month. Resident #14 was admitted to the facility on April 21, 2012, with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Hypertension. Medical record review of the physician's recapitulation orders dated August 2012, revealed "...change foley cath prn..." Medical record review of the current Interdisciplinary Care Plan last reviewed August 14, 2012, revealed "...change foley cath 1 time monthly..." Interview with the Assistant Director of Nursing (ADON) on August 22, 2012, at 11:40 a.m., confirmed the Care Plan had not been updated to reflect the resident's indwelling urinary catheter was to be changed as needed not every month.	F 280		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	{F 323}		8/22/12

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(F 323)	Continued From page 3 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to ensure a safety device was in place for one resident (#10), failed to reduce or eliminate side rails after a fall from the bed for one resident (#12), and failed to investigate a fall for one resident (#7) of eighteen residents reviewed. The findings included: Resident #10 was admitted to the facility on December 27, 2012, with diagnoses including Dementia with Behaviors, Depression, and Agitation. Medical record review of the Minimum Data Set (MDS) dated June 22, 2012, revealed the resident was cognitively intact for daily decision making, required extensive assistance for transfers and not steady moving from seated to standing position. Medical record review of the Interdisciplinary Care Plan last revised August 8, 2012, revealed "...is at risk for falls d/t (due to) unsteady balance while transferring...assist to wear non-slick footwear...instruct on safety measures to reduce the risk of falls...PSA (personal safety alarm) wc (wheelchair)/bed..."	(F 323)	**F323 Free of Accident Hazards/Supervision/Devices** 1. On 8/22/12, the ADON immediately re-assessed Resident #12 related to side rail use. Side rails were discontinued and the bed placed in the lowest possible position. On 8/22/12, the Charge Nurse replaced the PSA for resident #10. On 8/23/12, the Charge Nurse completed a 2nd incident report to replace the missing one for the 8/10/12 fall incident on resident #7. 2. The DON or one of the following: ADON, RN Supervisor, Wound Care Nurse, LPN Supervisor,	

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{F 323}	Continued From page 4 Medical record review of the physician's recapitulation orders dated August 2012, revealed "...Personal safety device due to decreased safety awareness..." Observation on August 22, 2012, at 8:20 a.m., in the resident's room, revealed the resident lying on the bed with no personal safety alarm in place. Observation on August 22, 2012, at 10:05 a.m., with Certified Nurse Aide (CNA) #1, revealed the resident sitting in a wheelchair. Continued observation and interview revealed no Personal Safety Alarm in place. Observation on August 22, 2012, at 10:45 a.m., with Licensed Practical Nurse (LPN) #1, revealed the resident sitting in a recliner, in the resident's room. Continued observation and interview revealed no PSA in place. Interview with the Assistant Director of Nursing (ADON) on August 22, 2012, at 11:50 a.m., in the conference room, confirmed the facility failed to ensure a Personal Safety Alarm was in place for resident #10. Resident #12 was admitted to the facility on July 27, 2011, with diagnoses including Chronic Heart Disease, Dysphagia, and Altered Mental Status. Medical record review of the Minimum Data Set (MDS) dated July 31, 2012, revealed the resident has severe cognitive impairment, independent with transfers and walking in room, and not steady moving from seated to standing position.	{F 323}	Charge will audit all resident care plans to ensure they include current fall interventions. To be completed by 8/23/12. The D.O.N. and A.D.O.N. completed an audit of all residents with side rails to ensure side rails were appropriately discontinued from residents who had experience a fall from the bed. Completed on 9/4/12. 3. The DON or ADON will in-service nursing staff in regards to: fall reporting, fall interventions, initiating investigations, updating those interventions on the care plan, discontinuing side rail use when a resident experiences a fall from the bed. To be completed by 8/24/12. The DON or one of the following: ADON, RN Supervisor, Wound Care Nurse, LPN Supervisor, Charge Nurses will conduct	8/23/12 9/4/12

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{F 323}	Continued From page 5 Medical record review of a nurse's note dated August 17, 2012, at 2:30 a.m., revealed "...resident observed lying on R (right) side in front of roommate's bed..." Medical record review of the interdisciplinary notes dated August 17, 2012, at 9:00 a.m., revealed "...observed in floor of room...bed alarm placed on bed to alert staff of unassisted ambulation..." Medical record review of the interdisciplinary Care Plan last revised August 17, 2012, revealed "...at risk for falls d/t (due to) unsteady gait, balance and hx (history) of falls...encourage to wear non-slick footwear...bed alarm...SR's (side rails) x (times) 2 per request bed mobility...encourage to ask for assist prior to transfer/ambulation attempts...side rails as ordered..." Review of the facility's Fall Investigation Tool, dated August 17, 2012 revealed when the fall occurred on August 17, 2012, the resident stated "I just fell". Continued review revealed the "...ordered restraint side rail device was in place..." Continued review of the Fall Investigation Tool revealed no investigation as to determine how the resident exited the bed while the side rail device was in place. Review of facility policy, Falls Investigation Procedure, dated January 2008, revealed "...if a fall occurs, the falls investigation tool is followed to ensure that the resident receives timely and appropriate care as well as follow up notifications and documentation...an investigation to assist in determining the root cause of the fall as well	{F 323}	random audits of resident care plans to ensure current fall interventions are reflected on the care plan. One of the individuals listed above will conduct random audits to ensure fall interventions are in place via walking rounds. Audits will be completed on 10 residents per week for 4 weeks, then 10 residents per month for 3 months. To begin the week of 9/3/12. 4. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate. August data to be reviewed at September Q.A. meeting and September	

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{F 323}	Continued From page 6 classifying the type of fall initiated..." Medical record review of a Therapy Screen dated August 17, 2012, revealed the resident had experienced a fall on August 17, 2012. Continued review of the Therapy Screen revealed "...resident observed on floor in room..." Observation on August 22, 2012, at 8:20 a.m., in the resident's room, revealed the resident lying on the bed with two one-half side rails attached to the middle of the bed in the up position. Interview with the Assistant Director of Nursing (ADON) on August 22, 2012, at 9:10 a.m., confirmed the resident had experienced a fall from the bed on August 17, 2012. The ADON stated the resident exited the bed with the side rails in the up position. The side rails remained in use while the resident was in bed until August 22, 2012, when the side rails were discontinued. Resident #7 was admitted to the facility on April 16, 2009, with diagnoses including Dementia without Behaviors, Osteoporosis, Depression and Alzheimer's Disease. Review of the significant change Minimum Data Set, dated May 16, 2012, revealed the resident scored a one out of fifteen on the Brief Interview for Mental Status (BIMS) indicating the resident was significantly cognitively impaired. Review of a nurse's note, dated August 10, 2012, at 8:00 p.m., revealed "...pt (patient) alarm went off found sitting on floor bed in lowest position..." Observation on August 22, 2012, at 8:17 a.m., in	{F 323}		

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(F 323)	Continued From page 7 the 100 Wing Hallway, revealed the resident sitting in the hallway in the wheelchair with a chair alarm in place. Review of facility policy, Falls Investigation Procedure, dated January 2008, revealed "...If a fall occurs, the falls investigation tool is followed to ensure that the resident receives timely and appropriate care as well as follow up notifications and documentation...an investigation to assist in determining the root cause of the fall as well classifying the type of fall initiated...Care plan interventions are changed or developed as a result of the investigation..." Interview with the Director of Nurses (DON) on August 22, 2012, at 10:30 a.m., in the conference room, revealed the facility did not have an investigation for the fall on August 10, 2012.	(F 323)		

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